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DISABILITY LAW NEWS

"Treating Physician" Regulations Eviscerated

In seemingly record time, the Social Security Administration's (SSA) Notice of Proposed Rule Making (NPRM) - *Revisions to Rules Regarding the Evaluation of Medical Evidence* - published in the Federal Register on September 9, 2016, became final on January 18, 2017. https://www.gpo.gov/fdsys/pkg/FR-2017-01-18/html/2017-00455.htm. These new regulations redefine several key terms related to evidence and revise the list of acceptable medical sources to include advanced practice registered nurses and physician assistants. But most significantly, under the new regulations SSA will no longer give a specific weight (i.e., controlling weight) to any medical opinions, including from the claimant's own healthcare providers.

SSA's professed goal in revising the rules is "to ensure that they reflect modern health delivery and are easier to understand and use." 82 Fed. Reg. 5844. They will become effective on March 27, 2017, but will only apply to cases filed on or after March 27th. A revised version of the current treating physician regulations, which incorporates some aspects of the now rescinded Social Security Ruling (SSR) 06-3p, will govern pending cases filed prior to that date. See 20 C.F.R. §§ 404.1527(f) & 416.927(f).

The proposed regulations were outlined in the October 2016 edition of the *Disability Law News*. http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/ssa-proposes-new-treating.html#.WIJlWssiy70. In response to the 383 comments received from individual citizens, claimants' representatives, members of Congress, professional organizations, and advocacy groups, SSA made some revisions to the proposed rules, including adding physician assistants in addition to nurse practitioners in the list of acceptable medical sources (AMS). A summary of the differences between the proposed and final rules is at 82 Fed. Reg. 5844-5845. But ultimately, the most significant proposed changes to the way evidence from treating sources is considered were retained.

Primacy of "treating source" opinions eliminated

In fact, the term "treating source" has been removed from the regulations, replaced by "your medical source." Relying heavily on the 2013 findings of the Administrative Conference of the United States (ACUS), SSA cited the burdensome number of findings required by adjudicators under the current rules, conflicting federal court

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perspectives, and the changing nature of the primary healthcare system as justification for the proposed changes. According to SSA, changes in how people receive primary care have undermined the presumption that a claimant’s sole treating physician has the longitudinal knowledge and unique perspective objective medical evidence alone cannot provide.

SSA’s response to public comments “recogni[zed] that an individual’s own medical source may have a unique perspective of an individual’s impairments.” 82 Fed. Reg. 5857. And SSA admitted that under 20 C.F.R. §§ 404.1520c & 416.920c, the “final rules also continue to allow an adjudicator to consider an individual’s own medical source’s medical opinion to be the most persuasive medical opinion if it is both supported by relevant objective medical evidence and the source’s explanation, and is consistent with other evidence” 82 Fed. Reg. 5853. But the value of opinions from treating sources is no longer acknowledged in the regulations themselves.

Weighing of evidence replaced by consideration of “persuasiveness”

Rather than weighing medical evidence from various sources, with special recognition of the intrinsic value of evidence from treating sources, SSA will now “consider” the “persuasiveness” of opinions from *all* medical sources. According to the preamble to the NPRM, SSA believed its current rules used “weigh” and “weight” in several confusing ways. The new regulations use the term “persuasiveness” instead of “weight,” and “consider” instead of “weigh. ” See Preamble to the September 2016 NPRM at 81 Fed. Reg. 62574. According to SSA in response to comments, the current regulations did not specify specific weights, other than “controlling.” As a result, adjudicators used a variety of terms, such as significant, great, little, more, and less. SSA hopes to avoid this confusion by having adjudicators focus on how persuasive they find opinions. 82. Fed. Reg. 5858. But is unclear how adjudicators, in rendering a “minimum level of articulation” required by the new regulations, will define or describe “persuasive.”

Opinions of all medical sources will be considered

On a positive note, in response to comments, SSA revised the proposed rules to reflect that “all medical sources” will include medical sources that are not acceptable medical sources. Per 20 C.F.R. §§ 404.1502 & 416.902, the definition of “medical source” is “an individual who is licensed as a healthcare worker by a State and working within the scope of practice permitted under State or Federal law…” According to SSA’s response to comments, the definition includes licensed mental health care providers. 82 Fed. Reg. 5847. So, for example, although SSA refused to include Licensed Clinical Social Workers in its final definition of “acceptable medical sources,” adjudicators will be required to consider the persuasiveness of their opinions under new 20 C.F.R. §§ 404.1520c & 416.920c. Objective evidence from non AMSs still can not be used to establish a “medically determinable impairment” (MDI) under 20 C.F.R. §§ 404.921 & 416.1521; their opinions as to functional limitations, however, will be “considered,” but not accorded any extra weight. This definition would presumably apply to physical therapists and chiropractors as well. (SSA claims this change will also allow it to select an individual’s own medical source, regardless of AMS status, as a preferred source to conduct consultative examinations. 82 Fed. Reg. 5847.)

Factors for considering “persuasiveness”

How will SSA consider the “persuasiveness” of all these medical opinions, including those from a claimant’s own medical sources, as well as prior administrative opinions from SSA’s medical and psychological consultants (MCs & PCs)? It will use several factors, with “relationship with the claimant” subsidiary to what SSA deems as the two most important factors: supportability and consistency. See 20 C.F.R. §§ 404.1520c(a) & 416.920c(a).

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The factors, in order of importance, are: 1) supportability; 2) consistency; 3) relationship with the claimant, combining the current examining and treatment factors; 4) specialization; and 5) other factors, which include familiarity with other evidence in the claim or an understanding of disability policies and evidentiary requirements. 20 C.F.R. §§ 404.1520c(c) & 416.920c(c). SSA admitted determining "consistency" might be challenging in certain claims, but refused to clarify what consistency means beyond acknowledging its use in the regulations is "the same as the plain language and common definition." 82 Fed. Reg. 5854. According to SSA, it "includes consideration of factors such as whether the evidence conflicts with other evidence from other medical sources and whether it contains an internal conflict with evidence from the same medical source." *Id.*

But SSA also acknowledged "that the symptom severity of some impairments may fluctuate over time, and we will consider the evidence in the claim that may reflect on this as part of the consistency factor as well." 82 Fed. Reg. 5854. SSA also acknowledged "that evidence from a medical source who has a longstanding relationship with a claimant may contain some inconsistencies over time due to fluctuations in the severity of an individual's impairments." SSA plans to include the extent to which such inconsistencies should be taken into consideration in its training to adjudicators. *Id.*

The proposed regulations had listed familiarity with the entire record and understanding of SSA policy as separate factors. The final version of the regulations combines them as "other factors," so as not to appear that SSA favors SSA's medical and psychological consultants (MCs & PCs) opinions. 82 Fed. Reg. 5857. SSA also revised the proposed rules to recognize that new evidence submitted after the MC or PC has rendered an opinion might make the opinion "more or less persuasive." 20 C.F.R. §§ 404.1520c(c)(5) & 416.920c(c)(5).

Of note, all of the factors except relationship specifically refer to persuasiveness. For example, the more supportable and consistent an opinion is, the more persuasive it will be. Or the opinion of a specialist may be more persuasive. In contrast, the factors under the relationship category are simply listed, and include length of relations, frequency of examinations, purpose and extent of treatment relationship, and examining relationship. 20 C.F.R. §§ 404.1520c(c)(3) & 416.920c(c)(3).

How will factors be "articulated"?

How the factors are "considered" will be "articulated" by the adjudicator. What do "consider" and "articulate" mean? In response to a comment, SSA declined to replace "consider" with "evaluate." According to SSA, "consider" is easily distinguishable from "articulate." "Adoption of the term 'evaluate' could imply a need to provide written analysis, which is not what we intend." 82 Fed. Reg. 5855. "Articulate," on the other hand, does seem to imply a written analysis. 20 C.F.R. §§ 404.1520c(b) & 416.920c(b) requires adjudicators "to articulate in our determination or decision how persuasive we find all the opinions." SSA revised 20 C.F.R. §§ 404.1520c(b)(1) & 416.920c(b)(1) to provide that adjudicators will articulate how they considered medical opinions, rather than merely consider them. It "expect[s] that the articulation requirements in these final rules will allow a subsequent reviewer or a reviewing court to trace the path of an adjudicator's reasoning." 82 Fed. Reg. 5858.

But SSA left intact the provisos that adjudicators are not required to articulate individually how they considered each medical opinion when a medical source provides multiple opinions. 20 C.F.R. §§ 404.920c(b)(1) & 416.1520c(b)(2). Nor are adjudicators required to explain how they considered the other factors besides consistency and supportability when they articulate their consideration of medical opinions. 20 C.F.R. §§ 1520c(b)(2) & 416.920c(b)(2). Those

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other factors, including relationship with claimant, must be articulated only if there are two or more conflicting but equally persuasive medical findings on the same issue that are equally well-supported and consistent. 20 C.F.R. §§ 404.1520c(b)(3) & 416.920c (b)(3). According to SSA, "it is not administratively feasible for us to articulate how we considered all of the factors for all of the medical opinions and prior administrative findings in all claims." 82 Fed. Reg. 5856.

Adjudicators will also be relieved of articulating how evidence from nonmedical sources was considered. Adjudicators will have discretion as whether they even have to discuss such opinions. 20 C.F.R. §§ 404.1520c(d) & 416.920c(d). Nonmedical sources include the claimant, educational personnel, social welfare agency personnel, and family members, caregivers, friend, neighbors, employers, and clergy. 20 C.F.R. §§ 404.1502 & 416.902. SSA did acknowledge in response to comments, however, that these nonmedical source "can provide helpful longitudinal evidence about how an impairment affects a person's functional abilities and limitations on a daily basis," especially in claims for child disability. 82 Fed. Reg. 5851. It refused, however, to give controlling or other weight to opinions from teachers. 82 Fed. Reg. 5858. But as noted above, claims filed before March 27, 2017, will be reviewed under the revised 20 C.F.R. §§ 404.1527(f) & 416.927(f). The new subsection incorporated the factors from the now rescinded SSR 06-3p for evaluating evidence from nonmedical sources.

Additions to List of Acceptable Medical Sources

In addition to these major changes on how opinion evidence is evaluated, the regulations revise and reorganize other existing regulations and Social Security Rulings (SSRs). As noted above, SSA has revised the rules for determining acceptable medical sources, now including nurse practitioners (Licensed Advance Practice Registered Nurses) and physician assistants, as well as audiologists. 20 C.F.R. §§ 404.1502 & 416.902.

Objective Medical Evidence

Objective medical evidence now includes signs *or* laboratory findings, or both, rather than the current signs *and* laboratory findings. 20 C.F.R. §§ 404.1502 & 416.902; 20 C.F.R. §§ 404.1513(a)(1) & 416,913 (a)(2). Of note, symptoms, diagnoses, and prognoses are not considered opinion evidence, but moved to the category of "other medical evidence." 20 C.F.R. §§ 404.1513(a)(3) & 416.913(a)(3). Administrative findings of fact and medical opinions from state agency medical and psychological consultants, other than ultimate determinations as to disability, are considered "prior administrative medical findings." 20 C.F.R. §§ 404.1513(a)(4) & 416.913(a)(4). SSA revised its proposed regulations to clarify that this term refers only to prior findings in a current claim. "These final rules do not affect our current policies about res judicata" effects of findings from earlier, separate claims. 82 Fed. Reg. 5852. Prior findings from current claims are considered under the same factors used to consider other medical opinions discussed above. New 20 C.F.R. §§ 404.1513a(b) & 416.913a(b) provide that evidence from state agency medical or psychological consultants must be considered by Administrative Law Judges (ALJ) under the opinion regulations discussed above, but ALJs are not required to adopt any prior administrative findings. See also 20 C.F.R. §§ 404.1520b(c)(2) & 416.920b(c)(2).

Decisions of Other Governmental Agencies

The new regulations rescind the provisions of SSR 06-3p related to decisions by other agencies. Decisions by other governmental agencies and nongovernmental entities are specifically categorized as "evidence that is inherently neither valuable nor persuasive." 20 C.F.R. §§ 404.1520b(c) & 416.920b(c). See also 20 C.F.R. §§404.1504 & 416.904. SSA addressed this issue extensively in the Preamble to the September Notice of Proposed Rule Making (NPRM) and in discussing the comments. Of note, two commenter questioned whether such decisions would have to be submitted under the "all evidence rules" at

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20 C.F.R. §§ 404.1512(a) & 416.912(a). SSA "clarified" this issue, responding that the decision "may not relate to whether or not an individual is blind or disabled under our rules." Adjudicators nevertheless will consider the relevant underlying supporting evidence. 82 Fed. Reg. 5849.

Other Inherently Non-persuasive Evidence

Other evidence inherently neither valuable nor persuasive includes statement reserved to the Commissioner. 20 C.F.R. §§ 404.1520b(c)(3) & 416.920b(c)(3). This includes statements that (i) a claimant is disabled or unable to work, (ii) has a severe impairment, (iii) satisfies the durational requirement, or (iv) meets or equals a listing; (v) define residual functional capacity (RFC) in SSA programmatic terms, (vi) RFC prevents the claimant from returning to past relevant work, or (vii) claimant does nor does not meet the requirements of the Medical-Vocational Guidelines.

Medical Determinable Impairments (MDI)

An MDI can only be established by objective medical evidence from an acceptable medical source (AMS). 20 C.F.R. §§ 404.1521 & 416.921. SSA has "clarified" that a medically determinable impairment (MDI) cannot be established by symptoms, diagnoses, or medical opinions. According to SSA in its Preamble to the NPRM, a diagnosis is not always reliable "because sometimes medical sources diagnose individuals without using objective medical evidence." 81 Fed. Reg. 62567.

Medical and Psychological Consultants

SSA amended several rules to conform to the Balanced Budget Amendment (BBA), which requires that medical consultants who review claims must be licensed physicians or psychologists.

SSRs Rescinded

SSRs 96 -2p, 96-5p, 96-6p, and 06-3p have been rescinded. But SSA plans to publish a new SSR outlining how ALJs and the Appeals Council would obtain evidence to make medical equivalency findings.

Effective Date

As noted above, the regulations become effective on March 27, 2017. [As of the date of publication of this newsletter, it does not appear these regulations will be affected by the new administration's freeze on new regulations.] But the regulations will only apply to claims filed on or after March 27th, so it may be some time before advocates begin to see their effect at the hearing level.

The current regulations will continue to apply to cases in the administrative pipeline and in U.S. District Court. SSA has, however, amended the current treating source regulations with a change that presumably will also take effect on March 27th but will apply to cases in the pipeline. It has added 20 C.F.R. §§ 404.1527(f) & 416.927(f). According to SSA, these sections incorporate the provisions of SSR 06-3p, which will be rescinded on March 27th. 82 Fed. Reg 5844. The new sections will govern the evaluation of evidence from non-acceptable medical sources and non-medical sources in pending claims. This category will include nurse practitioners and physician assistants, who will be considered "acceptable medical sources" only in claims filed on or after March 27, 2017.

There will be much for all of us to learn as we cope with this seismic shift. The Empire Justice Center will offer trainings in the near future. And we look forward to your insights and observations.

SSA Pays Small COLA for 2017

Monthly Social Security and Supplemental Security Income (SSI) benefits will increase 0.3 percent in 2017 due to a very small increase in the Consumer Price Index (CPI-W).

The monthly SSI federal benefit rate for an individual will go up $2 to $735; the monthly rate for a couple goes up $3 to $1,103. The New York supplement will continue at $87 for individuals and $104 for couples living alone; the living with others supplements remain at $23 and $46, respectively. A 2017 New York State SSI benefit chart is available at: http://otda.ny.gov/policy/directives/2016/INF/16-INF-18-Attachment-1.pdf

Thanks to Jim Murphy of Legal Services of Central New York, SSI benefit charts from 1976 to 2015 are available at http://www.empirejustice.org/issue-areas/disability-benefits/non-disability-issues/benefits-level-charts/ssi-benefit-levels-published.html.

With the small COLA, other of SSA's benchmarks also saw slight increases. Substantial Gainful Activity (SGA) threshold for Non-Blind has increased to $1,170 per month. The SGA level for blind workers went to $1,950. The Trial Work Period (TWP) threshold increased to $840 per month (from $810).

The quarter of coverage amount has increased to $1,300. The maximum taxable earnings for OASDI (old-age, survivors and disability insurance) purposes went to $127,200 in 2017.

Most beneficiaries will pay Medicare Part B monthly premiums of $109.00 per month in 2017. Some higher earning beneficiaries will have higher premium rates. For more details, see http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html.

For SSA's Fact Sheet on 2017 Social Security Changes, see https://www.ssa.gov/news/press/factsheets/colafacts2017.pdf.

SSA Discontinues Paper Statements

On January 9, 2017, the Deputy Commissioner of the Social Security Administration's (SSA) Office of Communications released a blog detailing recent changes in SSA services. In a cost-saving step, SSA will mail fewer paper Social Security Statements. Paper statements will only be sent to people age 60 and over, who are not getting benefits, and do not have a **my Social Security** account. Per the Deputy Commissioner, this will reduce costs of processing and mailing paper statements by $11.3 million in FY 2017.

http://blog.socialsecurity.gov/finding-value-and-my-social-security-in-light-of-budget-cuts/

DAP Advocate Takes Major Steps

Long-time DAP stalwart David Ralph of the Elmira office of LawNY took some major steps last year. Last Spring, David married Linda and simultaneously announced his retirement. The WNYDAP Task Force celebrated both events at its August meeting, pictured below. Not surprisingly to those who know him, David has not quite retired. He is still toiling away, finishing up his cases and continuing to provide his clients with the thorough and dedicated representation that has characterized his practice. We are sorry to see David leave, as we have relied on him as our collective conscious. He has never failed to remind us not to be complacent when our client's most basic due process rights are in jeopardy. We will miss him, but wish him and Linda all the best as they explore other roads in "retirement."

Changes Afoot at SSA

On Friday, January 20, 2017, Acting Commissioner of Social Security Carolyn W. Colvin resigned. Nancy A. Berryhill, Deputy Commissioner for Operations (DCO), will serve as Acting Commissioner based on SSA's succession plan.

The new Acting Commissioner has been with SSA for over 40 years. Prior to assuming the position of DCO, she was the Regional Commissioner of the Chicago region. She has held numerous management and technical positions in SSA. In one of her first acts as Acting Commissioner, Ms. Berryhill notified all SSA personnel of the hiring freeze imposed by the new president.

It remains unclear when a new Commissioner will be appointed by the president, or who that might be. The president's SSA transition team is apparently headed up by Mike Korbey, former senior advisor to the principal deputy commissioner at the Social Security Administration in George W. Bush's administration. Former Reagan Social Security Commissioner Dorcas Hardy, Former Social Security Inspector General Patrick O'Carroll, and former Social Security General Counsel David Black serve on the transition team, as does Tom Leppert, a former Republican mayor of Dallas. Several of these members have been known to support either partial privatization of Social Security and/or raising the retirement age.

REGULATIONS

Mental Impairment Listings Now In Effect

The Social Security Administration's (SSA) new Mental Impairment Listings went into effect on January 17, 2017. As we told you in the October 2016 *Disability Law News*, the revised Listings will be applied at all levels of administrative adjudication on the effective date. This means the new rules will be used by the Division of Disability Determination (DDD) at the initial determination level, the Administrative Law Judge (ALJ) at the hearing level, and the Appeals Council at the appeal level. Federal courts will be expected to review appeals under the rules in effect when the decisions were rendered. A court remand, however, will be governed by the new rules. https://www.federalregister.gov/documents/2016/09/26/2016-22908/revised-medical-criteria-for-evaluating-mental-disorders.

We are curious as to what training decision makers at each level have received on the new Listings, and are trying to get that information. In the meantime, please let us know what you are seeing in your decisions on these cases.

How will the new listings affect disability recipients who were allowed with the old listings, (especially the now extinct 12.05(c)) on Continuing Disability Reviews (CDRs)? According to the current POMS, SSA will look at the old listing to determine medical improvement. If a claimant still meets an old listing, disability continues. https://secure.ssa.gov/poms.nsf/lnx/0428015050. Thanks to Anthony Baer of LASN-NY, who asked and answered the question.

The Empire Justice Center has conducted a series of trainings on the new Mental Impairments Listings. If you missed one of the presentations, contact Kate or Louise for the materials, or visit http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/new-mental-impairment-listing.html#.WIojpcsiy70. And please be sure to let us know how you and your clients are faring under these new rules.

Final Regulations on NICS Database Issued

SSA issued final rules implementing the National Instant Criminal Background Check System (NICS) Improvement Amendments Act of 2007. Under these final rules, which came out on December 19, 2016, SSA will report individuals to NICS who receive Title II or SSI benefits based on a finding that the individual's impairment meets or equals listing 12.00 and requires a representative payee. Inclusion on the NICS database restricts the individual's ability to purchase firearms and certain explosives. NOSSCR and other advocates opposed this designation, arguing these criteria are both over and under inclusive, as not determinative of an individual's propensity for violence. 81 Fed. Reg. 91702 (Dec. 19, 2016). This final rule was effective on January 18, 2017. Compliance is not required until December 19, 2017.

https://www.gpo.gov/fdsys/pkg/FR-2016-12-19/pdf/2016-30407.pdf

HIV Listings Finalized

In February 2014, and corrected in March 2014, SSA issued a Notice of Proposed Rulemaking for Listings 14.00 and 114.00, used to evaluate claims involving human immunodeficiency virus (HIV) infection in adults and children. On December 2, 2016, the agency issued final rules adopting the proposed Listings except for some changes incorporating comments. 81 Fed. Reg. 86915 (December 2, 2016). https://www.gpo.gov/fdsys/pkg/FR-2016-12-02/pdf/2016-28843.pdf. The final rules went into effect on January 17, 2017.

According to SSA, this final rule reflects the agency's program experience and advances in medical knowledge since the HIV listing was last comprehensively revised in 1993; recommendations from a report SSA commissioned from the Institute of Medicine; and comments received from medical experts and the public at an outreach policy conference and in response to an advance notice of proposed rulemaking and notice of proposed rulemaking.

SSA made the following changes in the final rule:

- Revised and expanded the introductory text to the immune system disorders body system for evaluating HIV infection for both adults (14.00) and children (114.00);
- Revised the introductory text for the digestive, hematological, skin, and cancer body systems to update other references to HIV infection;
- Revised the introductory text for evaluating functional limitations resulting from immune system disorders for adults and children;
- Created listings 14.11 and 114.11 for HIV infection;
- Removed criteria for HIV infection that no longer represent impairments that are of listing-level severity;
- Re-designated and revised current criteria under 14.11 or 114.11, as appropriate;
- Reserved listings 14.08 and 114.08, the current listings for HIV infection; and
- Added new criteria for both adults and children for evaluation of HIV infection under the listings.

Correction Made to Expedite Reinstatement Revisions

Back on October 17, 2016, SSA revised the Expedited Reinstatement rules to allow a person to request reinstatement in the month s/he stops doing SGA instead of having to wait a month. The earliest effective reinstatement date remains the month following the last month in which SGA was performed. The revision is effective April 17, 2017. SSA made a technical correction to 42 C.F.R. § 404.1592f(a) to make it consistent with the revisions. The new text is also effective on April 17, 2017. 81 Fed. Reg. 7648 (Jan. 23. 2017).

https://www.gpo.gov/fdsys/pkg/FR-2017-01-23/pdf/2017-00076.pdf

Five Day Requirement Finalized

In another example of the Social Security Administration (SSA) acting with amazing haste, it published its final "program uniformity" regulations on December 16, 2017. https://www.gpo.gov/fdsys/pkg/FR-2016-12-16/pdf/2016-30103.pdf.

The July 2016 Notice of Proposed Rule Making proposed, among other things, closing the record five business days before a scheduled Administrative Law Judge (ALJ) hearing. The Empire Justice Center, a number of other advocacy organizations, and members of Congress voiced opposition to SSA's proposal. SSA, however, did not withdraw the five-day requirement.

SSA's ostensible goal in promulgating these changes is to "ensure national consistency in our policy and procedures and improve accuracy and efficiency in our administrative review process." 81 Fed. Reg. 09087. The changes will bring the rest of the nation in accord with practices in place in the Boston region (Region 1) for the past ten years. In implementing these new regulations, Part 405 of 20 C.F.R., which governed Region 1, has been removed.

Sections 404.935 & 416.1435 of 20 C.F.R. (Submitting evidence prior to the hearing before an administrative law judge) have been significantly revised. Claimants and their representatives must submit evidence, or inform SSA about it, at least five business days from the hearing, unless an exception applies. Unless an exception applies, the ALJ may decline to consider or obtain the evidence.

In response to comments, SSA revised the proposed regulation to clarify the circumstances described that would constitute good cause for a claimant or representative to submit evidence after the five-day deadline are not exclusive examples. The examples at 20 C.F.R. §§ 404.935(b)(3) & 416.1335(b)(3) include:

- serious illness,
- death or serious illness in the immediate family,
- important records were destroyed or damaged by fire or other accidental cause, or
- the claimant actively and diligently sought evidence from a source and the evidence was not received or was received less than five business days prior to the hearing.

In response to comments, SSA removed the phrase "through no fault of your own" from the last example "to reduce the evidentiary burden on claimants who are unable to produce evidence." 81 Fed. Reg. 90988. A claimant's physical, mental, educational, or linguistic limitation(s) preventing him or her from informing SSA about or submitting the evidence earlier could also constitute good cause. 20 C.F.R. §§ 404.935(b)(2) & 416.1435(b)(2).

In its commentary, SSA sought to reassure the public that these changes will not relieve adjudicators of their responsibility to make decisions based on the evidence presented at hearings. SSA argued the changes will promote both efficiency and fairness, citing experience in the Boston region. In response to many concerns raised by commenters, SSA reiterated the ability of ALJs to find exceptions to the requirement. It also claimed that responding to requests to submit evidence pursuant to one of the exceptions did not cause extra work in the Boston region. 81 Fed. Reg. 90989. In response to comments about "variances" in how ALJs in the Boston region applied similar rules, SSA promises to provide additional training to adjudicators and staff about applying the exceptions. 81 Fed. Reg. 90992.

SSA made several other changes to the proposed rule in response to comments. It amended 20 C.F.R. §§ 404.939 & 416.1439, 404.949 & 416.1449, and 404.950(d)(2) & 416.950(d)(2) to include exceptions to the deadlines for objecting to issues at a hearing, presenting written statements, and requesting subpoenas. Note that subpoenas must be requested at least *ten* business days before the hearing date, as opposed to the five-day time-frame in the current regulation. The five-day requirement does apply to objections to the issues and written statements. But SSA clarified that the five-day requirement only applies to pre-hearing written statements, not to post-hearing statements. 81 Fed. Reg. 90991. And SSA states that the exceptions could be relied upon to submit rebuttal evidence if an ALJ introduces new evidence at or after the hearing. *Id.*

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Five Day Requirement Finalized- Continued

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SSA agreed with comments that hearing notices should provide at least *75 days* before a hearing rather than the 60 days in the proposed rule. 20 C.F.R. §§ 404.938 & 416.1438.

The new regulations also affect the Appeals Council. It will consider new and material evidence that relates to the period on or before the date of the hearing decision only if there is a reasonable probability the evidence would change the outcome of the hearing decision. 20 C.F.R. §§ 404.970(a)(5) & 416.1470(a)(5). The Appeals Council regulations have also been amended to provide the Appeals Council will only consider new evidence if the claimant shows good cause for not informing SSA or submitting it in accordance with 20 C.F.R. §§ 404.935 & 416.1435. See 20 C.F.R. §§ 404.970(b) & 416.1470(b). The good cause exceptions are repeated in the Appeals Council regulation.

SSA withdrew its proposed rules allowing the Appeals Council to conduct a hearing to develop evidence. SSA disagreed with commenters who argued there was no legal basis for this proposed change, but nonetheless decided to remove the proposed rule. According to SSA, the Appeals Council will continue to exercise its authority to develop evidence in accordance with 20 C.F.R. §§ 404.976(b) & 416.1446(b). 81 Fed. Reg. 90989.

Several other sections have been reorganized or revised to cross reference the new regulations.

These new regulations will undoubtedly create new burdens and hassles for advocates already struggling to get evidence in a timely fashion. Advocates should keep in mind, however, that *informing* the ALJ of new evidence within the time frame should be sufficient to comply with the new requirements. SSA states in its commentary: “In addition, we note that if a claimant informs an ALJ about evidence 5 or more days before the hearing, there would be no need for the ALJ to find that an exception applies, because the claimant notified us prior to the deadline.” 81 Fed. Reg. 90990. Advocates will thus need to make sure they notify the ALJ in writing at least five days before the hearing that they anticipate receiving and submitting new evidence.

What is not clear, however, from the regulations and commentary is what procedures will be followed if an ALJ refuses to accept evidence proffered or finds it is not material. Section 404.951(b) (Contents of the official record) refers to, *inter alia*, “any additional evidence or written statements that the administrative law judge admits into the record under §§ 404.929 and 404.935.” (See also 20 C.F.R. § 416.1451(b)). Does evidence an ALJ excludes under the five-day requirement or rules as not material become part of the official record? Query whether uploading the evidence into ERE will secure it as part of the record? Advocates will need to make any disputes about the admission of evidence clear on the record to preserve the issue for appeal.

The new rules became effective on January 17, 2017. According to the notice, however, “compliance is not required until May 1, 2017.” Please keep us informed, come May, of how ALJs are implementing this new five-day requirement.

Contact Us!

Advocates can contact the DAP Support attorneys at:

Louise Tarantino: (800) 635-0355, (518) 462-6831, ltarantino@empirejustice.org
Kate Callery: (800) 724-0490, (585) 295-5727, kcallery@empirejustice.org
Ann Biddle: (347) 592-2214, abiddle@qls.ls-nyc.org

QDD and CAL Authority Continues

The Bipartisan Budget Act of 2015 (BBA) requires termination of the "single decision-maker" (SDM) authority for State Agencies (DDD in NY) making initial and, where applicable, reconsideration disability determinations. The "single decision maker" is referred to as a "Disability Examiner" and has no medical qualifications. The BBA required SSA to stop this test of decision making options and involve a medical professional.

Back on August 25th, SSA announced it will terminate the single decision maker test by December 28, 2018. SSA recently announced it is extending the authority for Disability Examiners to issue Quick Disability Determination (QDD) and Compassionate Allowance (CAL) approvals until December 28, 2018. The authority otherwise would have expired November 11, 2016. SSA promises this will be the final extension, explaining that it cannot extend it further because of the BBA prohibition on the single decision maker test. 81 Fed. Reg. 73027 (Oct. 24, 2016).

https://www.gpo.gov/fdsys/pkg/FR-2016-10-24/pdf/2016-25565.pdf

This is not a change to the QDD and CAL programs, which are intended to encourage State Agency reviewers to prioritize disability benefits claims that exhibit compelling circumstances, and allow them to cut certain procedural decision-making steps when the conclusions for those steps are clear from the outset, thus getting benefits into the hands of the most severely disabled with relative speed.

Proposed Rule on Attorney Conduct Withdrawn

On January 9, 2017, SSA withdrew its set of proposed final regulations on Revisions to Rules of Conduct and Standards of Responsibility for Appointed Representatives from review by the Office of Management and Budget. https://www.reginfo.gov/public/do/eoDetails?rrid=127107. The proposed regulations were summarized in the October 2016 edition of this newsletter.

This does not mean that this proposal is dead. It can be resubmitted by SSA after the change of administration, with or without change. The proposed rules can be found at https://www.gpo.gov/fdsys/pkg/FR-2016-08-16/pdf/2016-19384.pdf#page=1.

Send Us Your Decisions!

Have you had a recent ALJ or court decision that you would like to see reported in an upcoming issue of the *Disability Law News?*

We would love to hear from you!

Contact Kate Callery, kcallery@empirejustice.org and /or Louise Tarantino, ltarantino@empirejustice.org

iAppeals: A Rival to iTunes?

In December 2016, the Social Security Administration (SSA) added a piece to its online service. "iAppeals" allows individuals to file a request for reconsideration or a request for hearing for non-medical/non-disability related issues. This means that those who want to appeal a decision by SSA to reduce or suspend their Supplemental Security Income (SSI) benefits, or who want to appeal an overpayment decision by SSA, can use the iAppeals system to file their appeals.

The website to start a non-medical appeal is https://secure.ssa.gov/iApplNMD/start.

The claimant or a third party, including an appointed representative acting on the claimant's behalf, may access the iAppeals non-medical system to file an appeal on a non-medical issue. Using the iAppeals non-medical system to file such an appeal can have the benefits of filing the appeal quickly without having to go into a local SSA office if a deadline is approaching, and of having a record of exactly when the appeal was filed. We are hopeful that use of the iAppeal process will decrease the number of appeals lost, and increase the likelihood of an appeal being processed, and of aid continuation being provided, where appropriate.

New sections of the Program Operations Manual System (POMS) were released with more information about the iAppeals non-medical appeals process. Those sections include SI 04005.040, iAppeals Non-Medical for Title XVI (for SSI benefits), https://secure.ssa.gov/apps10/poms.nsf/lnx/0504005040 and GN 03101.127, iAppeals Non-Medical – General and Title II Instructions, https://secure.ssa.gov/apps10/poms.nsf/lnx/0203101127 .

This change is consistent with SSA's push to allow claimants to better manage their cases online. For example, in December 2016, SSA launched a new service for ***my*** Social Security account holders where the public can check on the status of an application for benefits or an appeal. This new addition will provide detailed information about retirement, disability, survivors, Medicare, and Supplemental Security Income claims and appeals filed either online at socialsecurity.gov or with a Social Security employee.

The service will provide important information about a claim or appeal, including:

- Date of filing;
- Current claim location;
- Scheduled hearing date and time;
- Re-entry numbers for incomplete applications;
- Servicing office location; and
- Claim or appeal decision.

Colvin Out; Berryhill In

As reported in this newsletter, Nancy A. Berryhill is the new Acting Commissioner of Social Security. She should be named as defendant in newly filed U.S. District Court appeals. Pending lawsuits naming former Acting Commissioner Colvin are covered by §25(d) of the Federal Rules of Civil Procedure, which provides that a successor public officer is automatically substituted as a party. The court may order substitution at any time, but the absence of such an order does not affect any substantial rights

COURT DECISIONS

Second Circuit Reverses on Duration Issue

In *Cutter v. Colvin* --- Fed.Appx. ---- , 2016 WL 7234685 (2d Cir. Dec. 14, 2016), Mr. Cutter appealed an unfavorable district court decision addressing the preclusionary effect of substantial gainful activity (SGA) in a disability determination. Mr. Cutter did not dispute that he engaged in a seven-month span of temporary employment, which counted as "substantial gainful activity." He also did not dispute that he failed to meet the necessary requirement of 12 -months of continuous disability, or that he should be labeled as "not disabled" for that time period. Instead, Mr. Cutter argued the court failed to consider whether, after leaving his job and therefore terminating all substantial gainful activity, Mr. Cutter's cognitive impairments "could be expected to last for a continuous period of not less than 12 months," potentially rendering him disabled under the Act. [42 U.S.C. § 423(d)(1)(A)].

The Second Circuit vacated and remanded the decision of W.D.N.Y. Judge Curtin, since Mr. Cutter's temporary employment did not preclude the application of the "expect to" test to the post-employment time period. The court distinguished Mr. Cutter's case from the holding in *Barnhart v. Walton*, 535 U.S. 212, 215 (2002), because Mr. Cutter had only "temporarily returned to work"; the plaintiff in *Barnhart* had "actual[ly] return[ed] to work." As the court stated, "neither 42 U.S.C. § 423(d)(1)(A) nor 20 C.F.R. § 404.1520(b) or other governing regulations necessarily disqualify Cutter from receiving disability benefits after [he terminated his substantial gainful activity]."

This is great outcome for this *pro se* plaintiff. Thanks to Stephanie Minerley, Albany Law School intern, for her summary of this decision.

Late Complaint Allowed as Timely Filed

We have cautioned in the past that missing appeals deadlines will at least cause some agita, if not outright panic. Those situations call for creative lawyering, as evidenced by a recent N.D.N.Y case.

Plaintiff filed a federal court complaint a few days beyond the 60 day appeal period. SSA moved to dismiss the complaint as untimely. After the Commissioner's motion was filed, plaintiff's attorney went to the Appeals Council and asked for an extension of time to file the federal court action. The Appeals Council granted the request and extended the time to file to the date the complaint was actually filed.

The Commissioner cried foul, arguing the Appeals Council had no authority to extend the time to file because the filing of plaintiff's complaint divested the SSA of jurisdiction, and in any event, the extension was improvidently granted.

Magistrate Judge Peebles disagreed with both of the Commissioner's arguments. The Magistrate Judge found the Commissioner was authorized to entertain requests for extensions of time to file civil action filed after commencement of the civil action pursuant to HALLEX 1-3-9-92(c). The Commissioner's argument that the Appeals Council could not provide the extension was therefore found to be without merit.

The court refused to review whether the extension was improvidently granted, noting the Appeals Council action was not a final decision of the Commissioner over which the court had jurisdiction pursuant to 42 U.S.C. §405(g). Magistrate Peebles denied the government's motion and allowed the complaint to go forward as timely filed. *Purcell v. Colvin*, 5:16-CV-0465 (DEP) (N.D.N.Y. Nov.4, 2016)(available as DAP # 582).

So just in case you think the Commissioner's lawyers are not counting to make sure your appeals are timely, think again. Congratulations to plaintiff's counsel, Paul Eaglin of Syracuse.

CE Lawsuit Settled

The U.S. District Court in San Francisco has preliminarily approved a settlement in a class-action lawsuit that challenged the Social Security Administration's (SSA) reliance on a Bay Area consultative examiner whose reports were unprofessional and often incomplete and inaccurate. The suit charged that SSA continued to use this doctor's reports to deny disability benefits for years, even after he was disqualified for failure to comply with notices of corrective action.

The settlement agreement would give many of the 6,500 class members who were examined by the now-disqualified doctor and had their benefits terminated or denied the option to have SSA re-determine their disability claims - without using that doctor's report. Under the agreement, Social Security also would review its own processes for monitoring the doctors contracted to conduct these exams in the future. Plaintiffs were ably represented by Morrison & Foerster LLP, Justice in Aging, and the Legal Aid Society of San Mateo County.

http://www.justiceinaging.org/our-work/litigation/hart-v-colvin-litigation/

WEB NEWS

"Pickle" People Qualify for Medicaid

Medicaid benefits can help increase the affordability of Medicare for some low-income people who qualify. In most states, one avenue for qualifying for Medicaid benefits is "Pickle" eligibility, which is available to certain individuals who once received both SSI and Social Security benefits but now only receive Social Security because their income exceeds SSI limits.

Older adults who are eligible through the Pickle Amendment can save hundreds or even thousands of dollars a year in Medicare Part B premiums and copayments. Younger adults with disabilities, particularly those who do not live in states that have expanded Medicaid, may also find Pickle eligibility to be a lifesaver.

Figuring out whether your client might qualify for Medicaid under Pickle rules can seem daunting, but thanks to a tool developed by the Tennessee Justice Center, it's really not hard at all. The tool has just been updated for 2017 and makes it easy to do the math to determine whether your client will qualify. Thanks to our colleagues at Justice in Aging for this valuable information.
http://www.justiceinaging.org/wp-content/uploads/2016/12/2017-Pickle-chart-revised-re.-209b-listing-12-22-16.pdf

SSA Partners with VA to Improve Services

On October 11, 2016, the Social Security Administration (SSA) and the U. S. Department of Veteran Affairs (VA) launched a new initiative to improve services to Veterans and their dependents who apply for Social Security disability benefits. This new national initiative enables Social Security disability processing sites to receive medical records electronically from all VA facilities via health information technology (health IT) through a system-generated request.

Health IT capability uses existing information systems and supports national standards, policies, and technology to share health information securely through the eHealth Exchange. This technology enables SSA to access veterans' health information electronically. Visit https://www.ssa.gov/disabilityssi/hit/

Baltimore Payment Center Contact Info

Trying to find out when your clients will actually receive benefits awarded to them? Or have an overpayment issue you need to discuss with the Payment center? The most up-to-date contact information for the Baltimore Payment Center is available at: https://www.ssa.gov/representation/pct_contact_info_under54.htm

Wayback Machine Archive Saves the Day

A recent query on the DAP listserv inquired about the availability of an old HALLEX section no longer available on SSA's website. DAP advocate Jim Murphy found the missing section using the website Wayback Machine, an internet archive site. According to its webpage, the site accesses more than 279 billion web pages saved over time. Check it out. https://archive.org/web/

SSA Field Offices Customer Waiting Times on the Rise

The Social Security Administration's (SSA) Office of the Inspector General issued a report in December 2016 documenting customer wait times at the Social Security Administration's (SSA) field offices. "Customer Waiting Times in the Social Security Administration's Field Offices" -Report Number: A-04-17-50216.

According to the report, SSA administers its programs and services through a network of approximately 1,220 field offices in 10 regions that serve the public throughout the United States. In 2011, SSA began reducing field offices' operating hours. As a result, as of the date of the review, field offices were opened to the public four hours fewer per week than before SSA made these changes.

According to SSA, the number of open field offices decreased from 1,238 field offices in FY 2010 to 1,219 field offices in FY 2015. Additionally, the number of field office employees declined approximately five percent from 29,114 in FY 2010 to 27,677 in FY 2015.

The total number of people visiting SSA field offices steadily increased between fiscal years (FY) 2006 and 2010. The number of visitors began declining in FY 2011, and declined each year through FY 2015 -- so much so, there were approximately 4.7 million fewer visitors to SSA field offices in FY 2015 than in FY 2010.

Despite significant decreases in SSA field office visits from FY 2010 to FY 2015, customer wait times have considerably increased. For all SSA regions, the average wait time increased 37 percent from FY 2010 to FY 2015. In contrast, the New York region experienced a more modest increase of eight percent, falling well below the national average.

The number of visitors to SSA field offices who waited longer than one hour for service also significantly increased from FY 2010 to FY 2015. In fact, for all regions, the number of field office visitors who waited longer than one hour for service increased from 2.3 million visitors in FY 2010, to 4.5 million visitors in FY 2015. That is a substantial 95 percent increase. Additionally, more than 11 percent of all visitors to SSA field offices waited longer than one hour for service in FY 2015. In contrast, only about five percent of visitors waited longer than one hour in FY 2010.

The Office of the Inspector General plans to conduct a follow-up review to examine factors affecting slow wait times and how SSA is managing field office wait times.

Thanks to Empire Justice Center paralegal Keith Jensen for summarizing this report, which is available at https://oig.ssa.gov/audits-and-investigations/audit-reports/A-04-17-50216

Requesting Correctional Facilities Records

Advocates face endless challenges requesting medical records to support their clients' disability claims, and complying with the Social Security Administration's "all evidence rules." See the March 2015 edition of this newsletter outlining the new rules. http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/final-submission-of-evidence.html#.WIkOQU0izcs . But those challenges are even greater when trying to secure medical records from New York State Department of Corrections and Community Supervision (DOCCS).

There are some guidelines for these requests, which are governed by http://www.doccs.ny.gov/Directives/2010.pdf. Special provisions for requesting mental health and drug and alcohol records are in section VII-D.

According to the directives, medical records of individuals can be requested under Public Officer's Law 87 (FOIL) or Public Health Law Section 18 and HIPPA. Requests for medical records should be in writing and addressed to the Nurse Administrator or Records Access Officer of the designated correctional facility. A valid authorization that complies with HIPPA is needed to send medical records to a third party. All requests for medical records received by the Records Access Officer must be acknowledged within five business days of receipt, informing the requester that the request is being forwarded and processed by the Nurse Administrator.

Mental health records are maintained by the Office of Mental Health (OMH) rather than DOCCS. Where the records are physically kept depends on the facility, and the amount of time the inmate has been absent from the facility. The Central New York Psychiatric Center in Marcy is technically the psychiatric center for all state prisons. See OMH website for a list of all psychiatric centers, and satellite units: https://www.omh.ny.gov/omhweb/bootstrap/providers.html

Requests for mental health records should be forwarded to the facility/ Satellite Mental Health Unit, Attention: Unit Chief. If the facility does not have a mental health unit, the requests should be forwarded to: Bureau of Forensic Services, 44 Holland Avenue, Albany, New York 12229.

Requests for records involving drug and alcohol treatment are even more complicated. According to the directive, the Department cannot release drug and alcohol records without (i) a court order (and ordinary subpoena is not valid); (ii) a request for such records by a hospital, physician or other health care provider in the case of a medical emergency; (iii) a request for certain drug and alcohol abuse records to which the Federal Regulations 42 CFR 2.11 et seq. do not apply; or (iv) a signed release by the subject of the record. A former inmate can authorize the release of drug and alcohol records by signing either departmental form #1079, "Release of Drug and Alcohol Abuse Records" (Department request), or form #1080, "Release of Drug and Alcohol Abuse Records."

Can DOCCS charge for these records? Again, per the Directive, the Department is not permitted to charge any fee for searching records on-site, for making them available for public inspection (unless redactions are required), or for certification of copies. The fee for photocopies of a Department record, however, shall be twenty five cents per page, for a paper copy, or the actual cost of reproducing the record. Postage may also be charged when copies are mailed.

For non-paper records (e.g., Loronix or other electronic records), the agency may charge the actual cost of reproducing a record if over two hours of staff time, or an outside professional service is needed to prepare a copy of the requested records. A person requesting a record should be informed of the estimated cost of preparing a copy for the record. Depending upon the relationship between the Department and the person requesting the records, the Assistant Records Offices may provide the records with a bill for fees due, require assurance of payment before

(Continued on page 19)

Requesting Correctional Facilities Records- Continued

(Continued from page 18)

copies of the record are delivered, or require payment in advance of delivery.

Note the fee will be waived when the documents are being provided to an agency of the Federal, State, or local government. The fee may be waived in the discretion of the Records Access Officer when circumstances warrant it.

It is not clear if DOCCS can be persuaded to waive fees pursuant to Sections 17 & 18 of the Public Health Law, which provide that a qualified person shall not be denied access to patient information solely because of inability to pay. Advocates report some success in this regard. Other advocates suggest requesting records be sent directly to SSA or the client's local Department of Social Services (DSS) to avoid fees.

Keep us informed about your successes—or lack thereof—in obtaining prison records. And thanks to Jim Murphy of the Cortland Office of Central NY Legal Services, and David Ralph of the Elmira office of LawNY for sharing their tips.

SSA Public Affairs Specialists Available

Did you know that the Social Security Administration (SSA) has Public Affairs Specialists (PAS) who might be able to answer your questions or even run interference with a District Office? They serve as spokespeople and trainers for SSA. They conduct briefings and workshops about all SSA-related issues, and often serve as ombudsman, reporting directly to their Area Directors.

Everett Lo (everett.lo@ssa.gov) heads SSA's New York Regional Public Affairs Office, but there are PASs throughout the state:

Mid / Lower Manhattan	Debbie Figueroa	debbie.figueroa@ssa.gov
Northern Manhattan	Shirley Saxton	shirley.saxton@ssa.gov
Bronx / Westchester	Bernie Rosen	bernard.rosen@ssa.gov
Lower Hudson Valley	Adrienne Vavricka	adrienne.vavricka@ssa.gov
Brooklyn, Queens & Long Island	Shauntell Greene Nilsa Henriquez	shauntel.greene@ssa.gov nilsa.henriquez@ssa.gov
Norther NYS (Albany)	Elizabeth Pivonka	elizabeth.pivonka@ssa.gov
Northern NYS (Buffalo)	Ben Stump	ben.stump@ssa.gov

See https://www.ssa.gov/ny/community.htm.

BULLETIN BOARD

This "Bulletin Board" contains information about recent disability decisions from the United States Supreme Court and the United States Court of Appeals for the Second Circuit. These summaries, as well as summaries of earlier decisions, are also available at www.empirejustice.org.

We will continue to write more detailed articles about significant decisions as they are issued by these and other Courts, but we hope that this list will help advocates gain an overview of the body of recent judicial decisions that are important in our judicial circuit.

SUPREME COURT DECISIONS

Astrue v. Capato, ex rel. B.N.C., 132 S.Ct. 2021 (2012)

A unanimous Supreme Court upheld SSA's denial of survivors' benefits to posthumously conceived twins because their home state of Florida does not allow them to inherit through intestate succession. The Court relied on Section 416(h) of the Social Security Act, which requires, *inter alia,* that an applicant must be eligible to inherit the insured's personal property under state law in order to be eligible for benefits. In rejecting Capato's argument that the children, conceived by in vitro fertilization after her husband's death, fit the definition of child in Section 416 (e), the Court deferred to SSA's interpretation of the Act.

Barnhart v. Thomas, 124 S. Ct. 376 (2003)

The Supreme Court upheld SSA's determination that it can find a claimant not disabled at Step Four of the sequential evaluation without investigation whether her past relevant work actually exists in significant numbers in the national economy. A unanimous Court deferred to the Commissioner's interpretation that an ability to return to past relevant work can be the basis for a denial, even if the job is now obsolete and the claimant could otherwise prevail at Step Five (the "grids"). Adopted by SSA as AR 05-1c.

Barnhart v. Walton**,** 122 S. Ct. 1265 (2002)

The Supreme Court affirmed SSA's policy of denying SSD and SSI benefits to claimants who return to work and engage in substantial gainful activity (SGA) prior to adjudication of disability within 12 months of onset of disability. The unanimous decision held that the 12-month durational requirement applies to the inability to engage in SGA as well as the underlying impairment itself.

Sims v. Apfel**,** 120 S. Ct. 2080 (2000)

The Supreme Court held that a Social Security or SSI claimant need not raise an issue before the Appeals Council in order to assert the issue in District Court. The Supreme Court explicitly limited its holding to failure to "exhaust" an issue with the Appeals Council and left open the possibility that one might be precluded from raising an issue.

Forney v. Apfel**,** 118 S. Ct. 1984 (1998)

The Supreme Court finally held that individual disability claimants, like the government, can appeal from District Court remand orders. In *Sullivan v. Finkelstein*, the Supreme Court held that remand orders under 42 U.S.C. 405 (g) can constitute final judgments which are appealable to circuit courts. In that case the government was appealing the remand order.

Shalala v. Schaefer**,** 113 S. Ct. 2625 (1993)

The Court unanimously held that a final judgment for purposes of an EAJA petition in a Social Security case involving a remand is a judgment "entered by a Court of law and does not encompass decisions rendered by an administrative agency." The Court, however, further complicated the issue by distinguishing between 42 USC §405(g) sentence four remands and sentence six remands.

SECOND CIRCUIT DECISIONS

***Lesterhuis v. Colvin,* 805 F.3d 83 (2d Cir. 2015)**

The Court of Appeals remanded for consideration of a retrospective medical opinion from a treating physician submitted to the Appeals Council, citing *Perez v. Chater*, 77 F.3d 41, 54 (2d Cir. 1996). The ALJ's decision was not supported by substantial evidence in light of the new and material medical opinion from the treating physician that the plaintiff would likely miss four days of work per month. Since the vocational expert had testified a claimant who would be absent that frequently would be unable to work, the physician's opinion, if credited, would suffice to support a determination of disability. The court also faulted the district court for identifying gaps in the treating physician's knowledge of the plaintiff's condition. Citing *Burgess v. Astrue*, 537 F.3d 117, 128 (2d Cir. 2008), the court reiterated it may not "affirm an administrative action on grounds different from those considered by the agency."

***Greek v. Colvin*, 802 F.3d 370 (2d Cir 2015)**

The court remanded for clarification of the treating source's opinion, particularly as to the claimant's ability to perform postural activities. The doctor had also opined that Mr. Greek would likely be absent from work more than four days a month as a result of his impairments. Since a vocational expert testified there were no jobs Mr. Greek could perform if he had to miss four or more days of work a month, the court found the ALJ's error misapplication of the factors in the treating physician regulations was not harmless. "After all, SSA's regulations provide a very specific process for evaluating a treating physician's opinion and instruct ALJs to give such opinions 'controlling weight' *in all but a limited range of circumstances*. See 20 C.F.R. § 404.1527(c)(2); see also Burgess, 537 F.3d at 128." (Emphasis supplied.)

***McIntyre v. Colvin*, 758 F.3d 146 (2d Cir. 2014)**

The Court of Appeals for the Second Circuit found the ALJ's failure to incorporate all of the plaintiff's non-exertional limitations explicitly into the residual functional capacity (RCF) formulation or the hypothetical question posed to the vocational expert (VE) was harmless error. The court ruled that "an ALJ's hypothetical should explicitly incorporate any limitations in concentration, persistence, and pace." 758 F.3d at 152. But in this case, the evidence demonstrated the plaintiff could engage in simple, routine tasks, low stress tasks despite limits in concentration, persistence, and pace; the hypothetical thus implicitly incorporated those limitations. The court also held that the ALJ's decision was not internally inconsistent simply because he concluded that the same impairments he had found severe at Step two were not ultimately disabling.

***Cichocki v. Astrue,* 729 F.3d 172 (2d Cir. 2013)**

The Court held the failure to conduct a function-by-function analysis at Step four of the Sequential Evaluation is not a *per se* ground for remand. In affirming the decision of the district court, the Court ruled that despite the requirement of Social Security Ruling (SSR) 96-8p, it was joining other circuits in declining to adopt a *per se* rule that the functions referred to in the SSR must be addressed explicitly.

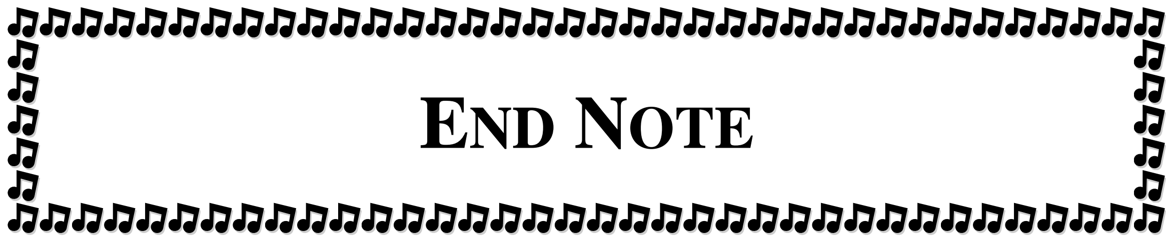
***Selian v. Astrue,* 708 F.3d 409 (2d Cir. 2013)**

The Court held the ALJ improperly substituted her own lay opinion by rejecting the claimant's contention that he has fibromyalgia despite a diagnosis by his treating physician. It found the ALJ misconstrued the treating physician's treatment notes. It criticized the ALJ for relying too heavily on the findings of a consultative examiner based on a single examination. It also found the ALJ improperly substituted her own criteria for fibromyalgia. Citing the guidance from the American College of Rheumatology now made part of SSR 12-2p, the Court remanded for further proceedings, noting the required finding of tender points was not documented in the records.

The Court also held the ALJ's RFC determination was not supported by substantial evidence. It found the opinion of the consultative examiner upon which the ALJ relied was "remarkably vague." Finally, the court agreed the ALJ had erred in relying on the Grids to deny the claim. Although it upheld the ALJ's determination that neither the claimant's pain or depression were significant, it concluded the ALJ had not affirmatively determined whether the claimant's reaching limitations were negligible.

***Talavera v. Astrue,* 697 F.3d 145 (2d Cir. 2012)**

The Court of Appeals held that for purposes of Listing 12.05, evidence of a claimant's cognitive limitations as an adult establishes a rebuttable presumption that those limitations arose before age 22. It also ruled that while IQ scores in the range specified by the subparts of Listing 12.05 may be *prima facie* evidence that an applicant suffers from "significantly subaverage general intellectual functioning," the claimant has the burden of establishing that she also suffers from qualifying deficits in adaptive functioning. The court described deficits in adaptive functioning as the inability to cope with the challenges of ordinary everyday life.



Are You Bored at Meetings?

If you find yourself bored at meetings, maybe it's because you shouldn't be there. Researchers have found meetings that appear to drag on too long or fail to engage participants might be the result of the wrong mix or number of people at the meeting.

When there are a large number of participants at a meeting, many feel less willing to contribute, resulting in what researchers describe as "social loafing." According Andrew Carton, assistant professor at the University of Pennsylvania's Wharton School, "meeting bloat" leads to participants blaming others for problems rather than actively working on solutions. Oversize groups can make it hard to work effectively.

In a December 21, 2016 *Wall Street Journal* article, several managers described their ideal meeting sizes. One described his experience of inviting 25 employees to develop a branding strategy. He found that participants wandered off track or repeated others' ideas, resulting in a frustrating and overly long meeting. He then shrank the meetings to four managers who had first gathered input from their teams. The smaller group was quickly able to focus a reach a decision.

Another manager touts his "Rule of Seven" for meetings when a decision is needed. Michael Mankins, a partner with Bain & Co., who is a researcher on how companies waste time, claims the likelihood of making a decision decreases by 10% for each participant beyond seven. Juli Smith, president of an executive search firm, recalls "a nightmare meeting with 30 people all trying to talk over each other." When the nonprofit group broke down into committees of three to five members, it achieved its objectives with "less infighting, less arguing and less ego-bruising," according to Smith.

Dr. Carton's research debunks common assumptions that better ideas are generated by large-group brainstorming. He thinks participants actually resist making novel or risky suggestions for fear of what others will think. He suggests allowing participants to submit their suggestions anonymously before the meeting. Another technique for larger brainstorming sessions is to pose a question and invite participants to write answers on sticky notes, which can be grouped on a board—avoiding repetition but promoting discussion.

So when you plan your next meeting, invite just the right number. Others may thank you for it!